Facial Reanimation

THE ARMAMENTARIUM FOR SURGICAL treatment of permanent facial paralysis is rapidly growing with many recent new developments. Individual variations of skin tone, age, completeness of paralysis and associated other sensory and motor nerve involvement require tailoring of the variously available surgical procedures to the individual patient's needs. Time tested techniques such as temporalis muscle transfer to reanimate the eyelids, lateral tarsorophy, supra-brow and nasolabial skin excisions and XII nerve transplant are all extremely useful in selected patients.

Newly developed techniques, such as gold weights to help close the upper eyelid and silicone rubber slings surrounding the palpebral fissure, all hold considerable promise. The most recently introduced procedures include VII nerve crossover grafts, using a sural nerve graft to bridge from the normal side to the paralyzed side. Also newly reported are free muscle grafts, using the short toe extensors onlaid onto functional muscle with the tendons aligned to reanimate the paralyzed side. These newer procedures are extremely promising but will require the test of time to prove their efficacy.

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Undesirable Side Effects Following Intralesional Corticosteroid Therapy

INTRALESIONAL INJECTION of keloids with corticosteroid preparations was first advocated in 1951 but it was not until after the introduction of triamcinolone acetonide (Kenalog®) in 1961 that the use of this type of therapy became popular. Triamcinolone diacetate (Aristocort®) and betamethasone (Celestone®, Soluspan®) are also reported as effective agents but they are employed less commonly than Kenalog.

Unfortunately, the widespread use of these agents has led to indiscriminant use leading to an increasing incidence of side effects.

Systemic reactions such as syncope, anxiety, profuse sweating, chest and back pain and collapse have been described.

Plastic surgeons are seeing the undesirable local side effects more frequently each year. The most common of these are excessive atrophy of the surrounding subcutaneous tissues along with changes in pigmentation. Both hypo-pigmentation and erythema may occur with hypo-pigmentation being more common.

In addition, dermatologists are employing intralesional corticosteroid therapy in a multitude of skin disorders, including granuloma annulare, alopecia areata, lichen simplex chronicus, psoriasis, chronic eczema, discord lupus erythematosus, herpes simplex, and acne "nodules."

Although it is not always true, local adverse reactions generally follow the use of excessive dosages of triamcinolone. Definite standards of treatment and dosage schedules should be followed to minimize these adverse reactions. First of all, strict sterile technique must be adhered to. Second, care must be taken so the agent is injected only intralesionally with no injection into the surrounding or deep subcutaneous tissues. Thirdly, dosage schedules should be followed. The following schedule, which was evolved at the University of Kansas during the treatment of over 500 keloids can be recommended.

Adults: Maximum dose, 120 mg—may be repeated once a month for six months.

Lesion—1 to 2 square cm—20-40 mg; 2 to 6 square cm—40-80 mg; 6 to 10 square cm—80-100 mg

Children: Maximum dose, each treatment:

1 to 2 years of age—20 mg; 3 to 5 years of age —40 mg; 6 to 10 years of age—80 mg

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